

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

The bottom copy may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01687

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY CAROLINE CITY (If outside corporate limits, write RURAL OR and give nearest town) DENTON TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY CAROLINE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN DENTON STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) ANNA SABANDA BREEDING				4. DATE OF DEATH FEB 15 1959			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH MAY 7, 1874	9. AGE last birthday yrs. 84	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	(Year) Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JOSEPH CHERRY				14. MOTHER'S MAIDEN NAME (unknown) - DOUGLAS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) No			16. SOCIAL SECURITY NO. -	17. INFORMANT & ADDRESS (Mrs. Mark) Signett, Denton, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 442X IMMEDIATE CAUSE (A) Cardiovascular Renal Disease ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) General Arteriosclerosis GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (b) (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Myocarditis							
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) Greensboro, Md. (County) Greensboro (State) Md.			
21d. TIME OF INJURY (Month) Mar. (Day) 10 , (Year) 1958 (Hour) 11:30A		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Mar. 10, 1958 , to Feb. 15, 1959 , that I last saw the deceased alive on Feb. 15, 1959 , and that death occurred at 11:30A , from the causes and on the date stated above. SIGNATURE Charles H. Stonerifer M.D. Greensboro, Md. Feb. 17 '59 ADDRESS (Street, city, town, state) Tillaboro, Md. (State) Md. DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb 16, 1959		NAME OF CEMETERY OR CREMATORIAL Greenmount		LOCATION (City, town, or county) Tillaboro, Md. (State) Md.	
24. REC'D BY REGISTRAR FEB 24 '59		REGISTRAR'S SIGNATURE Charles H. Stonerifer		25. FUNERAL DIRECTOR'S SIGNATURE J. Wayne Moore		ADDRESS Tillaboro, Md.	
DATE Feb 24 '59							

SECURITY INFORMATION - THIS PAGE IS UNCLASSIFIED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1684

CERTIFICATE OF DEATH

01688

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware		b. COUNTY Sussex		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bridgeville - Rural		46 X 3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 314 Greenridge Road				d. STREET ADDRESS Near Atlanta		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First William	Middle Harvey	Last Britton	4. DATE OF DEATH	Month February	Day 22	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 13, 1880		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Wilmington, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James Britton			14. MOTHER'S MAIDEN NAME Kiziah Talley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. J. Thomas Mills, Federalsburg, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) ADVENTURE DUE TO ADVANCED. (c) SENILITY (SENIILE STATE)			CORONARY ARTERY SCLEROSIS, DIFFUSE, ADVANCED, WITH MYOCARDIAL FAILURE, TERMINAL.			INTERVAL BETWEEN ONSET AND DEATH 3 HRS.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) AORTIC ANEURISM, ARCH, ARTERIOSCLEROTIC						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 10/24/52, 19, to 2/22/59, 19, that I last saw the deceased alive on 2/21/59, 19, and that death occurred at 3:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE R. H. Beckert, M.D. BRIDGEVILLE, DELAWARE ADDRESS (Street, city or town, state) DATE SIGNED 2/24/59								
PHYSICIAN'S NAME (Type) R. H. BECKERT, M.D.		BRIDGEVILLE, DELAWARE						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 25, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery		22d. LOCATION (City, town, or county) Federalburg, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		ADDRESS Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE FEB 27 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

СЕВЕРНО-КАЗАХСКОЕ ТЕМБРОВОЕ ОБЛАСТИ

СТАДИОНАРНЫЙ

1935

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1685

CERTIFICATE OF DEATH

Reg. Dist. No.

01689

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near American Corner		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Herman	Middle Jefferson	Last Conley
4. DATE OF DEATH	Month February	Day 2	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1885
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME E. Francis Conley		14. MOTHER'S MAIDEN NAME Mollie Butler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 218-34-9251	17. INFORMANT Mrs. Daisy F. Conley, Federalsburg, Md. RFD	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stokes Adams Syndrome		INTERVAL BETWEEN ONSET AND DEATH 10 min	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO (b) One to two heartblock DUE TO (c) Arteriosclerotic Heart Disease	
3 weeks		5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/29 , 19 45 , to 2/2 , 19 59 that I last saw the deceased alive on 1/3/59 , 19 58 , and that death occurred at 10 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Preston Md.	
ACTUAL SIGNATURE Daisy B. Plummer		DATE SIGNED 2/4/59	
PHYSICIAN'S NAME (Type) Dr. H.B. Plummer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 5, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery		22d. LOCATION (City, town, or county) Federalsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR FEB 6 '59	
		24b. REGISTRAR'S SIGNATURE Caroline L. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1929

NAME OF DECEASED

HESKETH

ADDRESS

110 E. 22nd St.

DEATH DATE

1929

NAME

HESKETH

MATERIAL

LIVER

NO. OF
ORGANS

1

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1686

CERTIFICATE OF DEATH

Reg. Dist. No.

01690

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - Rural		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harmony		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - Rural	
d. STREET ADDRESS Harmony		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bessie Middle Washington Last Haynes		4. DATE OF DEATH Month February Day 5 Year 19 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 11, 1893
8. AGE (In years lost birthday) yrs. 65		9. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	10. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Green		14. MOTHER'S MAIDEN NAME Annie Friend	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 219-05-8810	17. INFORMANT Corenia M. Cook, Preston, Maryland, R.F.D.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Address INTERVAL BETWEEN ONSET AND DEATH 4 mo	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Coronary Thrombosis 4 mo	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension 20 years Right hemiplegia 5 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 20, 1929, to Feb 5, 1959, that I last saw the deceased alive on Feb 5, 1959, and that death occurred at 4:15 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. Paul Knotts</i>		ADDRESS (Street, city or town, state) Denton, Md	
DATE SIGNED			
PHYSICIAN'S NAME (Type) E. Paul Knotts M.D.		22. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Feb. 9, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Harmony Cemetery	22d. LOCATION (City, town, or county) (State) Preston, Maryland, R.F.D.
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR FEB 16 '59 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 DEPARTMENT OF DEFENSE STATE CHARTER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01691

1687

1. PLACE OF DEATH o. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton		c. LENGTH OF STAY IN 1b 5 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgely Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - Rural	
3. NAME OF DECEASED (Type or print) First William		f. STREET ADDRESS Harmony	
3. NAME OF DECEASED (Type or print) First William		g. DATE OF DEATH Month February Day 3 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-0624	17. INFORMANT Mrs. Nina Harrington, Delmar, Del., R.F.D.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. Bronchitis Chronic		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prostate Chronic		5 yrs 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1958 , to Feb. 3 1959 , that I last saw the deceased alive on Feb. 3 1959 , and that death occurred at 10:16 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dawson O. George</i>	M.D.	ADDRESS (Street, city or town, state) Aurora Md.	DATE SIGNED 2-5-59
PHYSICIAN'S NAME (Type) Dawson O. George, M.D.	Denton, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 6, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Union Grove Cemetery	22d. LOCATION (City, town, or county) Near Preston, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR FER 11 '59	24b. REGISTRAR'S SIGNATURE Charles L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

31 ЭКОНОМ-ПЛАН ЗА ТЕМПОВЫЕ ПРОГНОЗЫ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1688

CERTIFICATE OF DEATH

Reg. Dist. No.

01692

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Goldsboro		c. LENGTH OF STAY IN 1b 38 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Goldsboro	
f. STREET ADDRESS None		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Linda		First V.	Middle Hutson
4. DATE OF DEATH 2	Month 10	Day 19	Year 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/30/1920
9. AGE (In years lost at birth) 38 yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bates Smith		14. MOTHER'S MAIDEN NAME Rhoda Evans	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-12-1451 17. INFORMANT Joseph Hutson Rural Goldsboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Metastatic Obstruction of lower end of ureters		INTERVAL BETWEEN ONSET AND DEATH Hydronephrosis & Pyonephrosis (bilateral)	
DUE TO (b) Metastatic Obstruction of lower end of ureters			
DUE TO (c) Carcinoma of the cervix			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1958 to Feb. 10, 1959, that I last saw the deceased alive on Feb. 10, 1959, and that death occurred at 140A M, from the causes and on the date stated above. ACTUAL SIGNATURE Chas. H. Stonesifer, M.D. ADDRESS (Street, city or town, state) Chas. H. Stonesifer, M.D. Greensboro, Md. DATE SIGNED Feb. 11 '59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/13/59	
22c. NAME OF CEMETERY OR CREMATORIUM Greensboro		22d. LOCATION (City, town, or county) Greensboro, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaire, Greensboro, Md.		ADDRESS DATE FEB 16 '59	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur J. Knapp	

BY BROWNSTEIN & JAHN TO THE ATTACHED STATEMENT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

n1693

1689

CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH a. COUNTY Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md.		b. COUNTY Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		c. LENGTH OF STAY IN 1b 6 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Willoughby Nursing Home		d. STREET ADDRESS rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mary E. Mc Mahon		First	Middle	Lost	4. DATE OF DEATH Feb. 5, 1959	Month	Day	Year 19
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1886	9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY housewife		11. BIRTHPLACE (State or foreign country) Cokesbury, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Edward Lyons		14. MOTHER'S MAIDEN NAME Amanda Fisher						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ne		17. INFORMANT Harvey H. Mac Mahon		Address Federalsburg, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO CoryoNgrey Occlusion		INTERVAL BETWEEN ONSET AND DEATH 5 MIN				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO Cerebral Hemorrhage & Hemiplegia		1954				
(c) DUE TO Generalized Arteriosclerosis				?				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Federalsburg, Md.		(State)
21. I certify that I attended the deceased from Mar. 28, 1958 to Feb. 5, 1959 , that I last saw the deceased alive on Feb. 3, 1959 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Federalsburg, Md.		DATE SIGNED Feb. 6, 1959		
ACTUAL SIGNATURE W. E. Lennon		M.D.						
PHYSICIAN'S NAME (Type) W. E. Lennon								
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/8/59		22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Cem.		22d. LOCATION (City, town, or county) Federalsburg, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Harvey Willinsky		ADDRESS Federalsburg, Md.		24a. REC'D BY REGISTRAR Feb. 9 '59		24b. REGISTRAR'S SIGNATURE Carroll S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
WILLIAM H. COOPER	65	M	CHRONIC RHEUMATOID ARTHRITIS
ADDRESS	AGE AT DEATH	TIME OF DEATH	PLACE OF DEATH
100 W. 12TH ST., NEW YORK CITY	1885	10:00 A.M.	HOSPITAL
NAME AND ADDRESS OF PHYSICIAN	NAME AND ADDRESS OF FUNERAL DIRECTOR		
DR. JAMES M. COOPER, 100 W. 12TH ST., NEW YORK CITY	W. H. COOPER, 100 W. 12TH ST., NEW YORK CITY		
NAME AND ADDRESS OF PERSON REPORTING	RELATIONSHIP TO DECEASED		
W. H. COOPER, 100 W. 12TH ST., NEW YORK CITY	SPOUSE		
DATE OF DEATH	TIME OF DEATH	PLACES OF DEATH	
APRIL 10, 1910	10:00 A.M.	HOSPITAL	
NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
WILLIAM H. COOPER	65	M	CHRONIC RHEUMATOID ARTHRITIS
ADDRESS	AGE AT DEATH	TIME OF DEATH	PLACE OF DEATH
100 W. 12TH ST., NEW YORK CITY	1885	10:00 A.M.	HOSPITAL
NAME AND ADDRESS OF PHYSICIAN	NAME AND ADDRESS OF FUNERAL DIRECTOR		
DR. JAMES M. COOPER, 100 W. 12TH ST., NEW YORK CITY	W. H. COOPER, 100 W. 12TH ST., NEW YORK CITY		
NAME AND ADDRESS OF PERSON REPORTING	RELATIONSHIP TO DECEASED		
W. H. COOPER, 100 W. 12TH ST., NEW YORK CITY	SPOUSE		
DATE OF DEATH	TIME OF DEATH	PLACES OF DEATH	
APRIL 10, 1910	10:00 A.M.	HOSPITAL	

FOR STATE

HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1690 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01694

Reg. Dist. No. 64

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		c. LENGTH OF STAY IN 1b 35 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS River Road	
3. NAME OF DECEASED (Type or print) Oscar B. McLain		First Oscar	Middle B.
4. DATE OF DEATH Feb. 1 1959		Lost McLain	Month Day Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Sept. 22, 1906		9. AGE (In years from birthday) 52 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John B. McLain		14. MOTHER'S MAIDEN NAME Joda Lewis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. no	
17. INFORMANT Norman McLain		Address D. Federalsburg, R. F.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 322.0 DUE TO Alcoholism Acute INTERVAL BETWEEN ONSET AND DEATH 2 wks- Conditions, if any, which gave rise to immediate cause (b) Alcoholism Chronic Several yrs- (c) Peptic Ulcer 2 yrs- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Federalsburg (County) Caroline (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Lawson O. George		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Lawson O. George		DATE SIGNED 2-4-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-5-1959	
22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Cemetery		22d. LOCATION (City, town, or county) Federalsburg, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey W. Schenck - Federalsburg, Md.		ADDRESS	
		24a. REC'D BY REGISTRAR DATE FEB 9 '59	
		24b. REGISTRAR'S SIGNATURE Calvin S. Haas	



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155.10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1691

CERTIFICATE OF DEATH

01695

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	CAROLINE MARYLAND		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	MARYLAND COUNTY CAROLINE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS	LENGTH OF STAY (in this place)		STREET ADDRESS	(If rural give location)			
3. NAME OF DECEASED (Type or Print)				(First) KATHARINE (Middle) NICHOLS (Last)		4. DATE OF DEATH FEB. 28 1959	
S. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct. 19, 1884	9. AGE last birthday 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME David Todd		14. MOTHER'S MAIDEN NAME Susan Taylor					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. —		17. INFORMANT & ADDRESS		INTERVAL BETWEEN ONSET AND DEATH	
—		—		Hers Ollie Rogers, Denton, Md		8 days	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
33IX IMMEDIATE CAUSE (A) Cerebral Hemorrhage							
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2-20, 1959, to 2-28, 1959, that I last saw the deceased alive on 2-17, 1959, and that death occurred at 3:30 A.M. from the causes and on the date stated above.							
SIGNATURE Lawson D. George M.D.				ADDRESS (Street, city, town, state)		DATE SIGNED 3-3-59	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Mar. 3, 1959		NAME OF CEMETERY OR CREMATORIAL Denton		LOCATION (City, town, or county) Denton, Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Charles P. ...		25. FUNERAL DIRECTOR'S SIGNATURE J. T. Gilmore		ADDRESS Denton, Md	
DATE MAR 4 '59							

07 AUGUST 1974 TO THE PLATE 5000 AND UP

ITEMS TO ATTACHES



ITEMS TO ATTACHES



ITEMS TO ATTACHES



ITEMS TO ATTACHES

MARYLAND STATE DEPARTMENT OF HEALTH-BAL
CERTIFICATE OF DEATH

01696

1692

1. PLACE OF DEATH a. COUNTY CAROLINE		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before death) b. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRESTON		c. LENGTH OF STAY IN 1b 25 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS X PRESTON MAIN ST.	
3. NAME OF DECEASED (Type or print) Artie Raymond Poole		4. DATE OF DEATH Feb. 27	Month Day Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 9 1880
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) merchant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James H. Poole		14. MOTHER'S MAIDEN NAME Mary Fleetwood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-30-9287	
17. INFORMANT Wm. B. Poole		Address Darlington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Intestinal Anerysm		INTERVAL BETWEEN ONSET AND DEATH immediate	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anterior abdominal Dislocation		15 yrs.	
(c) Auricular Dislocation		5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to 2/27 , 1959, that I last saw the deceased alive on 2/20 , 1959, and that death occurred at 1st M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Preston Maryland			
ACTUAL SIGNATURE Harold B. Plummer		DATE SIGNED Plummer	
PHYSICIAN'S NAME (Type) Dr. Harold B. Plummer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 2, 1959	22c. NAME OF CEMETERY OR CREMATORIAL Methodist Church Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam		ADDRESS Easton, Md.	24a. REC'D BY REGISTRAR Mar 2 '59
			24b. REGISTRAR'S SIGNATURE O. L. - 8 hours

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return it by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WYOMING STATE DEPARTMENT OF NATURAL
RESOURCES
CERTIFICATE OF DATA

1995

DATA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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11697

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1693

1. PLACE OF DEATH a. COUNTY Caroline		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg		c. LENGTH OF STAY IN 1b 4 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Caroline		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 305 Park Avenue						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg				
3. NAME OF DECEASED (Type or print)		First Frank	Middle 	Last Ricketts	4. DATE OF DEATH February 4 1959	Month February	Day 4	Year 1959	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 1, 1880		9. AGE (In years lost yrs.) 78	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS. Days 	12. Hours 	13. Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engine Wiper		10b. KIND OF BUSINESS OR INDUSTRY in Merchant Marine		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Martha Ricketts						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-14-2483		17. INFORMANT Madeline Ricketts, Federalburg, Maryland		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 		Cardiac Failure		INTERVAL BETWEEN ONSET AND DEATH 1 wk.				
		(b) DUE TO Arteriosclerotic Heart Disease		Arteriosclerotic Heart Disease		20 yrs.				
		(c) DUE TO Generalized Arteriosclerosis		Generalized Arteriosclerosis		30 yrs.				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from _____, to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.							ADDRESS (Street, city or town, state)	DATE SIGNED		
ACTUAL SIGNATURE <i>H.R. Trapnell</i>		M.D. 126 Bloomingdale Rd					2-9-59			
PHYSICIAN'S NAME (Type) H.R. Trapnell		Federalburg, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 9, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Federal Hill Cemetery		22d. LOCATION (City, town, or county) Federalburg, Maryland			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalburg, Maryland		ADDRESS J.J. Frampton and Son, Federalburg, Maryland		24a. REC'D BY REGISTRAR FEB 16 '59		24b. REGISTRAR'S SIGNATURE <i>Civilian & Home</i>				

87390MITSUBISHI HEAVY INDUSTRIES LTD. OF JAPAN

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1694 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Federalsburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Federalsburg - Denton Highway			d. STREET ADDRESS 310 Park Avenue		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First James	Middle Rudolph	Last Ricketts	4. DATE OF DEATH Month February Doy 25 Year 1959
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH October 24, 1924	9. AGE (In years last birthday) 34 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory		11. BIRTHPLACE (State or foreign country) Federalsburg, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Clarence Turner			14. MOTHER'S MAIDEN NAME Ida Mae Ricketts		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. WW II		17. INFORMANT Address Ida Mae Garfield, Federalsburg, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 816 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Sudden		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 2 Car collided			
20c. TIME OF INJURY Hour 6:10 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 313	20f. (City or town) Rural Federalsburg Caroline Md	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Dawson O. George		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2-25-59	
EXAMINER'S NAME (Type) Dawson O. George, M.D.		220. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF March 2, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Federal Hill Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		ADDRESS J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE FEB 27 '59	
				24b. REGISTRAR'S SIGNATURE Orion S. Hanes	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1695 CERTIFICATE OF DEATH

01699

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		COUNTY Caroline (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		life		X Rural Denton			
3. NAME OF DECEASED (Type or Print) EMMA LOUISE THOMPSON				4. DATE OF DEATH Feb 16, 1959			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH JAN. 19, 1915	9. AGE last birthday 44 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	(Year) Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ralph Meredith		14. MOTHER'S MAIDEN NAME Sarah Rickards					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. Ralph Meredith Denton, Md		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 153.9 IMMEDIATE CAUSE (A) <u>Cancer of Intestine</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb 7, 1959, to Feb 16, 1959, that I last saw the deceased alive on Feb 14, 1959, and that death occurred at 10 A.M. from the causes and on the date stated above.							
SIGNATURE <u>Dawson O George</u> M.D. ADDRESS (Street, city, town, state) <u>Denton, Md</u> DATE SIGNED <u>2/17/59</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb 19, 1959		NAME OF CEMETERY OR CREMATORIAL Denton		LOCATION (City, town, or county) Denton, Md	
24. REC'D BY REGISTRAR DATE FEB 24 '59		REGISTRAR'S SIGNATURE Arthur S. Kraus		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. W. George Funeral Director, Denton, Md.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**1696 CERTIFICATE OF DEATH**

Reg. Dist. No.

01780

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	<i>Caroline</i>	MARYLAND	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	<i>Maryland</i>	COUNTY <i>Caroline</i>
LENGTH OF STAY (In this place)			STREET ADDRESS (If rural, give location)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS	<i>Ridgely</i>		<i>Ridgely</i>		
3. NAME OF DECEASED (Type or Print)			4. DATE (Month) (Day) (Year)		
<i>ANNA ELIZABETH TURNER</i>			FEB 1 1959		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>July 25 1875</i>	9. AGE last birthday <i>83</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>of Maryland</i>	11. BIRTHPLACE (State or foreign country) <i>Caroline Tatnaw</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Noah Turner</i>			14. MOTHER'S MAIDEN NAME <i>Caroline Tatnaw</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>			16. SOCIAL SECURITY NO. <i>—</i>		
17. INFORMANT & ADDRESS <i>Mrs Gertrude Cannon Ridgely</i>			18. MEDICAL CERTIFICATION <i>Chronic Myocarditis</i>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>422.1</i> IMMEDIATE CAUSE (A) <i>Chronic Myocarditis</i> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) <i>Arteriosclerotic Cardiovascular</i> GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Disease</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>Apr. 10, 1958</i> , to <i>Feb. 1, 1959</i> , that I last saw the deceased alive on <i>Feb. 1, 1959</i> , and that death occurred at <i>6:30 AM</i> , from the causes and on the date stated above. SIGNATURE <i>Charles H. Stoeneker</i> ADDRESS <i>Greensboro, Maryland</i> DATE SIGNED <i>Feb. 3 1959</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			DATE THEREOF <i>Feb 4 1959</i>	NAME OF CEMETERY OR CREMATORIAL <i>Denton</i>	LOCATION (City, town, or county) (State) <i>Denton, Md</i>
24. REC'D BY REGISTRAR			REGISTRAR'S SIGNATURE <i>Charles H. Stoeneker</i>		
DATE <i>Feb 6 '59</i>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Charles H. Stoeneker</i>		

БІЛОРУСЬ-РІВНІ ІЗ СТАНДАРТЫ СТАВОЧНО

НТАЗ РО СТАНДАРТЫ АВІ

МІНІСТРСТВО

ІНДУСТРІЇ ІННОВАЦІЙ

ІНДУСТРІЇ
ІННОВАЦІЙ

ІНДУСТРІЇ ІННОВАЦІЙ

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ІНДУСТРІЇ ІННОВАЦІЙ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1697 CERTIFICATE OF DEATH

Reg. Dist. No.

01701

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg		c. LENGTH OF STAY IN 1b Life				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Walkertown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Lola Middle Helen Last White		4. DATE OF DEATH Month February Day 10 Year 1959				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 2, 1887			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland				
13. FATHER'S NAME Daniel Alford		14. MOTHER'S MAIDEN NAME Sarah Ellen Murphy				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 219-07-6147				
17. INFORMANT Mrs. George Eisenhower, Seaford, Delaware		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs.</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <i>Feb 10, 1959</i> , to <i>Feb 10, 1959</i> , that I last saw the deceased alive on <i>Feb 10, 1959</i> , and that death occurred at <i>11:30 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED <i>Frank M. Anderson, M.D. Feb 10, 1959</i>		
ACTUAL SIGNATURE <i>Frank M. Anderson, M.D.</i>		PHYSICIAN'S NAME (Type) Frank M. Anderson, M.D.		Federalburg, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 14, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery		22d. LOCATION (City, town, or county) Federalburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalburg, Maryland		ADDRESS J.J. Frampton and Son, Federalburg, Maryland		24a. REC'D BY REGISTRAR DATE FEB 16 '59		24b. REGISTRAR'S SIGNATURE <i>John E. Knob</i>

1903 CERTIFICATE OF DEATH

DECEASED PERSON'S NAME MRS. MARY E. SMITH	AGE 60	SEX F	DEATH DATE JULY 1, 1903
ADDRESS 123 W. 12TH ST., BALTIMORE, MD.			
NAME AND ADDRESS OF DOCTOR DR. JAMES H. SMITH, 123 W. 12TH ST., BALTIMORE, MD.			
NAME AND ADDRESS OF FUNERAL DIRECTOR H. C. SMITH, 123 W. 12TH ST., BALTIMORE, MD.			
NAME AND ADDRESS OF CEMETERY BALTIMORE CEMETERY, BALTIMORE, MD.			
TIME OF DEATH 12:00 P.M.			
CAUSE OF DEATH DISEASE			
SPECIAL INSTRUCTIONS None			
SIGNATURE OF CLERK J. H. SMITH			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1698

CERTIFICATE OF DEATH

Reg. Dist. No.

01702

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston		c. LENGTH OF STAY IN 1b Life long	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward Orland Wright		First Edward	Middle Orland
Last Wright		4. DATE OF DEATH Month Feb.	Day 22
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Aug. 28, 1880		9. AGE (In years last birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. James Wright		14. MOTHER'S MAIDEN NAME Mary Estella Hawes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-36-0057	
17. INFORMANT Clara T Wright		Address Preston, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Adrenal Insufficiency (Cortigoic) DUE TO 420.0 INTERVAL BETWEEN ONSET AND DEATH 3 weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Congestive Failure DUE TO 1 month			
(c) Arteriosclerotic heart disease DUE TO 10-15 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute Rheumatoid - later chronic, c Gouty Arthritis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/26 , 19 39 , to 2/21 , 19 59 , that I last saw the deceased alive on 2/21 , 19 59 , and that death occurred at Preston , M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Jane H. Plummer		ADDRESS (Street, city, or town, state) Preston, Maryland	
PHYSICIAN'S NAME (Type) Dr. H. B. Plummer		DATE, SIGNED 2/23/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 25, 59	
22c. NAME OF CEMETERY OR CREMATORIAL Jr. O.U.A.M.		22d. LOCATION (City, town, or county) (State) Preston	
23. FUNERAL DIRECTOR'S SIGNATURE J. M. J. Plummer		24a. REC'D BY REGISTRAR Preston	
ADDRESS Preston, Md.		24b. REGISTRAR'S SIGNATURE Md.	
DATE FEB 25 '59		24c. REC'D BY REGISTRAR 2/25/59	

